occurring in ageing and sun-damaged scalps of elderly patients and is characterized by recurrent pustulation, erosions, crusting and scars.[1] A recent article drew attention to the high incidence of antecedent local trauma.[2] Six of 12 cases had had shingles in the ophthalmic division of the trigeminal nerve before the characteristic changes of erosive pustular dermatosis appeared in the scalp (Figure 1). I have made a survey of the incidence of erosive pustular dermatosis in a series of patients who had been admitted to hospital with shingles affecting the scalp. I wrote to the general practitioners of all patients admitted with herpes zoster of the V_1, C_2 or C_3 dermatomes to the Infectious Diseases Unit, Chaddon Road Hospital, Somerset in 1980–85.

Forty four general practitioners were questioned about 58 patients and replies were received for 52 (27 male, 25 female). Forty eight patients had shown no evidence of erosive pustular dermatosis at the time of the survey although six had died and two had moved from the practice. For four patients the general practitioner suspected the diagnosis from the description in the circular letter but had not made the diagnosis before reading it. Two of these patients had died but both had persistent crusting which started at the time of their shingles and lasted until their deaths 18 months and three years later, respectively. I examined the other two patients — one showed a mixture of excoriations and actinic keratoses on a bald scalp and the other had flakes of adherent keratin and marked dysaesthesia on the right frontal scalp, presumably owing to lack of washing, but no crusts or pustules.

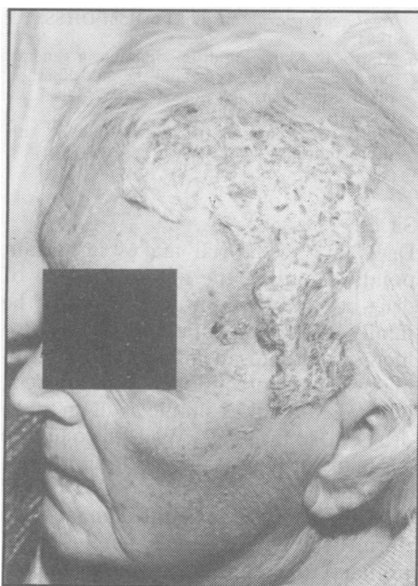

Figure 1. *Persistent crusting of the frontal scalp presenting 12 months after herpes zoster ophthalmicus. (Reproduced from reference 2 with permission of Blackwell Scientific Publications.)*

This survey suggests that erosive pustular dermatosis is an uncommon complication of herpes zoster affecting the scalp. The six cases reported earlier[2] had been collected from dermatology clinics in Avon, Somerset, and the Midlands over a six-year period. However, it is likely that more cases would be recognized if general practitioners and dermatologists were more aware of the disorder. Artefactual excoriation and accumulation of keratin owing to post-herpetic neuralgia need to be excluded. Debridement of the crusts, topical steroid applications and treatment of secondary infection with systemic antibiotics can all be helpful in the management of these patients, although the condition tends to run a protracted and relapsing course, sometimes until death from unrelated causes.

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Minimizing waiting times in open surgeries

Sir,
The assumption that 'for the majority of patients and doctors a well-organized appointment system has made life much more pleasant'[1] has been called into question, at least from the patients' point of view, by Allen and colleagues (April *Journal,* p.163), who found that satisfaction was related to the length of time patients spent sitting in the waiting room.

It is accepted that in a system with no appointments patients have to wait for long periods, but with some flexibility the waiting can be brought down to the levels of a well organized appointment system. I have found that the secret of success is to start with a nearly empty waiting room. This can be achieved by starting the surgeries about half an hour before the advertised starting time. The system is self-regulating, as during busy periods, patients arrive early 'to be seen first', and they are pleasantly surprised when they are invited in straight away. Because there are many things which can be done as well before as after a surgery, such as dictating letters and telephoning, it is not a strain on the doctor's time to arrive well in advance of the official opening of the surgery.

The essence of an 'open surgery' is that everybody is seen, and as the number of patients who attend a particular surgery is variable, the duration of the surgery should vary as well. Having two variable times instead of one, minimizes the waiting which necessarily occurs when the doctor starts with a crowded waiting room.

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Hospital discharge communications: information given to patients with cancer

Sir,
The content of hospital discharge communications has long been under discussion in the medical journals.[1] It has been noted that often the report does not tell the general practitioner what information has been given to the patient concerning the illness.[2] If the diagnosis is cancer, it is especially important that the general practitioner should be aware of what the patient has been told.

In this four partner practice of 8000 patients, consultations were monitored between 1979 and 1986. A record was made of the names of patients in whom a diagnosis of cancer was first recorded between these dates. The first and second communications from hospital were then analysed.

A diagnosis of cancer had been made in 77 patients. For 68 (88%) of these patients, neither the first nor the second discharge communications made any reference to any information given. Letters concerning seven patients (9%) unequivocally informed the general practitioner of what the patient had been told, for six of these patients (8%) the information was given in the first communication and for one patient (1%) in the second. Letters concerning a further two patients (3%) contained phrases from which it could be inferred that the patient was aware of the diagnosis.

These findings suggest that even in the case of a patient with cancer, the discharge

communication is unlikely to mention what information has been given to the patient. It is obviously undesirable for a general practitioner to know that the patient before him or her has cancer, yet to have no idea what the patient has been told. The effort required to improve this aspect of hospital discharge communications is very small.

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Unilateral headache

Sir,
During the last 12 months I have seen four patients with unilateral headache, three of whom also had ipsilateral tinnitus. The symptoms had lasted for three weeks or more and all the patients were women, aged 39–56 years. On enquiry, all four patients described having had cold sores of the lip or nasal area on the ipsilateral side, between three and 13 weeks before the headache appeared.

Joseph and Rose[1] have suggested a possible link between herpes simplex and cluster headache in a 42-year-old man. In their case, the headache actually preceded the cold sore by four to five weeks. Hardebo,[2] from Sweden, described a 32-year-old man who had chronic left-sided cluster headache one week after ipsilateral herpetic labial lesions. In neither case was tinnitus a feature.

Cluster headaches tend to affect men. In my cases the headache was mainly temporal, spreading over the eye and on to the maxillary area. The eye tended to water. The pain was present throughout the day, with several episodes of increased severity.

It seems possible that the herpes simplex virus can affect the trigeminal nerve. It is more difficult to explain how the virus affects the vestibular nerve. I wonder how frequently unilateral persistent headache in middle-aged females may be attributable to herpes simplex infection?

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Management of drug abuse in general practice

Sir,
I was interested to read the editorial by Dr Chang (June *Journal*, p.248) and I particularly approved of the way that she highlighted the benefits to be gained by an addict from membership of Narcotics Anonymous and of the help that families can obtain from their membership of Families Anonymous. I was also struck by her last paragraph where she mentions the benefit that doctors obtain from their contact with these patients.

However, I was disturbed that the editorial was presented as a clinical impression. It was unreferenced and statements such as 'Methadone is at present considered to be the drug of choice for detoxification' and 'Maintenance prescribing is actually counter-productive to recovery' were unsupported. The editorial also did not mention the fact that patients who misuse drugs are a heterogeneous population with only 0.03% of heroin users remaining in a phase of long-term dependent use.[1]

G.E. Vaillant of Harvard University medical school in his centennial address to the Society of Addiction in 1984 commented that the mean period of addiction for long-term heroin addicts was 10 years. This suggests that if addicts can survive and be supplied with drugs in a controlled fashion for an average of 10 years then they are likely to give up. If we accept this and also take into account the dangers of adulterants in street heroin[2-4] there is a case to be made for supplying methadone under controlled conditions for some addicted patients over a longer period than the short reduction schedules mentioned in the government guidelines.[5] The government itself has recognized that the rising incidence of the acquired immune deficiency syndrome has changed the cost-benefit equation in supplying maintenance methadone prescriptions for some long-term addicts. This is not necessarily a policy of despair and a *carte blanche* for providing drugs forever to addicted patients. However, it does involve a redefinition of one's aims in looking after these patients. In my practice our overall aim is to help addicted patients to lead a drug-free life. By supplying them, first of all, with a methadone prescription we try to give them personal space to plan for any changes in their life that are necessary to becoming drug free.[6]

One final criticism of the editorial is that the author does not produce any outcome measures for the method of management she is advocating. In my practice we have carried out an audit.[7] We have looked after 31 patients over four years and three have become drug free. One patient, who in the eight years before he was cared for by the practice had never been out of prison for more than four months at a time, has now been out of prison for four years, has stopped sleeping rough on the river banks and has his own council flat. One girl who remains addicted to a low dose of methadone has had a baby after several terminations of pregnancy. One family who had their children taken into care have got their children back and are living a relatively stable life. One man who used to drink 150 units of alcohol per week as well as taking methadone is now teetotal.

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Sir,
Dr Chang's editorial makes important points regarding the natural history of drug use and the appropriate use of the family as a therapeutic resource. It also highlights the disadvantages of prescribing by general practitioners. The answers, however, are not as simple as 'Don't take drugs; go to meetings'. While the outcome for many drug users is a natural progression to the drug-free state over a period of years (and meetings) the damage done during these years must surely be of primary concern. Short term abstinence may not be possible and many drug users continue to inject in an increasingly controlled way with the sort of support suggested by the author. It is important, however, to mention the increasing